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No. 06-923

IN THE

Supreme Court of the United States

METLIFE (METROPOLITAN LIFE INSURANCE COMPANY) AND LONG TERM DISABILITY PLAN FOR ASSOCIATES OF SEARS, ROEBUCK AND COMPANY,

Petitioners,

v.

WANDA GLENN,

Respondent.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Sixth Circuit

SUPPLEMENTAL BRIEF FOR PETITIONERS

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RULE 29.6 STATEMENT

The corporate disclosure statement included in the petition for a writ of certiorari remains accurate.

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SUPPLEMENTAL BRIEF FOR PETITIONERS

Pursuant to this Court's Rule 15.8, petitioners MetLife (Metropolitan Life Insurance Company) and Long Term Disability Plan for Associates of Sears, Roebuck and Company respectfully submit this supplemental brief in response to the brief of the United States as *amicus curiae* filed on December 21, 2007.

As the United States makes clear, this Court's review is warranted to resolve "the entrenched disagreement[ ] in the courts of appeals" as to whether courts reviewing a decision by an ERISA claim administrator that both evaluates and pays claims should weigh that fact so that the standard of review is changed when reviewing the administrator's claim determination. U.S. Br. 11. Although the United States' position on the merits of that question is legally flawed, its brief removes any conceivable doubt about the compelling need for this Court to provide authoritative guidance on that important issue.

The United States is incorrect, however, when it recommends denial of review on the second question presented. That question is independently certworthy because the Sixth Circuit's holding that a claim administrator such as MetLife must always provide a written refutation of a disability determination by the Social Security Administration ("SSA") directly conflicts with the holdings of four other circuits (*see* Pet. for Writ of Cert. 17), and is inconsistent with this Court's decision in *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 833-34 (2003). Equally importantly, the additional question proposed by the United States—which seeks clarification of the standard for reviewing benefits determinations by claim administrators with a mere structural conflict—is legally and logically antecedent to

the question whether a court may decide that a claim administrator abuses its discretion if it does not refute an SSA disability determination in writing. Without first determining the appropriate standard of review, it is impossible to decide whether a claim administrator's failure to provide an explicit refutation of an SSA disability determination is a ground for overturning a termination of benefits. The question proposed by the United States is therefore implicit in and fairly encompassed by the second question presented.

Moreover, as the United States acknowledges, the second question presented is inextricably intertwined with the fact-intensive, totality-of-the-circumstances reasonableness inquiry that the United States proposes as the appropriate standard of review in this case. The United States is thus simply splitting hairs when it suggests that the second question presented should be briefed in conjunction with the questions on which the United States does support review, but not granted plenary review in its own right. U.S. Br. 21.

Indeed, nothing in the United States' brief ameliorates the fundamental conflict between the Sixth Circuit's holding that a claim administrator abuses its discretion if it does not refute in writing an SSA disability determination and this Court's conclusion in *Nord* that a claim administrator is not required to give special weight to—or explain its disagreement with—the views of the treating physician. 538 U.S. at 834. Because the SSA *is* required to give special weight to a treating physician's views, the Sixth Circuit's holding represents an impermissible end run around this Court's decision in *Nord*.

The petition should therefore be granted in its entirety and, if the Court concludes that a mere structural conflict of interest should be weighed so as to change the judicial standard of review of the administrator's benefit determination, it should address the additional standard-of-review question posed by the United States in conjunction with its resolution of the second question presented.

I. THIS COURT SHOULD REVIEW WHETHER A CLAIM ADMINISTRATOR THAT EVALUATES AND PAYS CLAIMS OPERATES UNDER A CONFLICT THAT CHANGES THE STANDARD OF REVIEW.

Review of the first question presented is necessary to resolve an intractable split in lower-court authority and correct the Sixth Circuit's erroneous construction of ERISA.

A. As the United States recognizes, the circuits "are clearly in disarray on the issue" whether a so-called "dual-role plan administrator"—here, a claim administrator responsible both for making benefits determinations and paying claims—should always be treated as operating under a conflict of interest that must be weighted to change the standard of review of the administrator's benefit determination. U.S. Br. 9. Indeed, "how courts should review discretionary benefits denials by potentially conflicted [claim] fiduciaries in ERISA cases has bedeviled the federal courts ever since" *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), was decided. *Wagener v. SBC Pension Benefit Plan – Non Bargained Program*, 407 F.3d 395, 402 (D.C. Cir. 2005) (alteration in original; internal quotation marks omitted).

These conflicting lower-court decisions substantially undermine ERISA's objective of "ensur[ing]

that plans and plan sponsors would be subject to a uniform body of benefits law." *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 656 (1995) (internal quotation marks omitted). Without this Court's review, claim fiduciaries that make benefits determinations and pay claims will continue to be subject to one conflict-of-interest standard in the Third, Fourth, Fifth, Sixth, Eighth, Ninth, and Eleventh Circuits—which have held that a claim administrator that evaluates and pays claims is so conflicted that this fact should heighten the standard of review—and a different standard in the First and Seventh Circuits—which apply a case-by-case approach to determine whether a conflict of interest exists that alters the standard of review. *See* Pet. for Writ of Cert. 6-10.

This Court's review is urgently required to resolve this pervasive disagreement among the lower courts. This case is an ideal vehicle for resolving that split because—as the United States acknowledges—the Sixth Circuit's conclusion that MetLife was operating under a conflict of interest was essential to its decision to reinstate respondent's long-term disability benefits. *See* U.S. Br. 13 (explaining that the purported conflict of interest was one of the factors that, "'taken together,'" required reversal) (quoting Pet. App. 25a) (alteration and emphasis omitted).

B. The need for this Court's review is reinforced by the fact that the Sixth Circuit's holding—that claim administrators that make benefits determinations and pay claims are *always* so conflicted as to change the standard of review—is inconsistent with this Court's decision in *Firestone*, and with Congress's objectives when enacting ERISA.

The United States contends that, where a claim administrator both evaluates and pays claims, "every exercise of discretion impacts [the administrator] financially, filling or depleting its coffers." U.S. Br. 13 (alteration in original; internal quotation marks omitted). This facile generalization disregards the fact that Congress explicitly authorized fiduciaries to perform multiple roles. *See* 29 U.S.C. § 1102(c). It also reflects a fundamental misunderstanding of the economics of plan administration. The potential for a conflict of interest is often neutralized by other market forces—such as the insurer's incentive to "sell policies" and the employer's incentive to offer insurance programs with which its employees will be satisfied—that may offset the risk that an insurer will be "overly tight-fisted." *Wright v. R.R. Donnelley & Sons Co. Group Benefits Plan*, 402 F.3d 67, 75 (1st Cir. 2005).

Thus, while *some* claim administrators that both evaluate and pay claims may have acted due to that conflict of interest, the mere fact that an administrator performs dual functions is not sufficient, standing alone, to demonstrate the existence of a conflict that should alter the standard of review. In fact, no showing of an actual conflict was made in this case.

II. THE QUESTION WHETHER A CLAIM ADMINISTRATOR ABUSES ITS DISCRETION IF IT DOES NOT REFUTE AN SSA DETERMINATION IN WRITING ALSO WARRANTS REVIEW.

The United States' contention that this Court should deny review of the second question presented is unpersuasive. That question is eminently cert-worthy both because it fairly encompasses—and is inextricably intertwined with—the standard-of-

review question posed by the United States and because the Sixth Circuit's holding that a claim administrator abuses its discretion if it does not refute an SSA determination in writing conflicts with the decisions of other circuits and with this Court's decision in *Nord*.

A. The second question presented independently warrants review by this Court because it implicates a deep division among the circuits as to whether a claim administrator is required to refute an SSA disability determination in writing or risk the reversal of its determination. *See* Pet. for Writ of Cert. 17-19. The United States provides no persuasive basis for leaving that conflict unresolved and also fails to acknowledge that the question that it proposes for review—which asks this Court to clarify the manner in which courts should account for a conflict of interest when reviewing discretionary benefits determinations by claim administrators that both evaluate and pay claims—is an essential legal predicate to the second question presented. Indeed, a court cannot determine the legal implications of a claim administrator's failure to provide a written refutation of an SSA disability determination without first settling upon the standard to be used to review the claim administrator's decision. The question proposed by the United States is therefore fairly encompassed by the second question presented and—if the Court does conclude that MetLife was operating under a conflict of interest that alters the standard of review—should be resolved by the Court in the course of deciding the merits of that question. *See Ohio v. Robinette*, 519 U.S. 33, 38 (1996) (an "issue . . . [that] is a predicate to an intelligent resolution of the question presented" is "fairly included therein") (internal quotation marks omitted).

As the United States explains, lower courts have adopted at least three different approaches to reviewing benefits determinations by a claim administrator found to be operating under a conflict of interest: abuse-of-discretion review that takes account of a conflict of interest as one relevant factor, *de novo* review, and burden-shifting. U.S. Br. 9. This conflict can be resolved through a straightforward application of this Court's decision in *Firestone*, which held that, where a claim administrator possesses discretionary authority to determine eligibility for benefits, a "conflict must be weighed as *a factor* in determining whether there is an abuse of discretion." 489 U.S. at 115 (emphasis added; internal quotation marks and alteration omitted). *Firestone* therefore authoritatively forecloses the use of a *de novo* standard of review or burden-shifting to review a benefits determination by a conflicted claim administrator, especially one operating under a mere structural conflict. A court should instead review that decision under a reasonableness-based abuse-of-discretion inquiry that considers the totality of the circumstances surrounding the benefits determination.

The Sixth Circuit purported to apply that standard (Pet. App. 9a), but then proceeded to engage in a reevaluation of some of the medical records and other evidence before the claim administrator in what amounted to *de novo* review of the factual record. *See, e.g., id.* at 10a-24a. Moreover, at several points throughout its opinion, the Sixth Circuit faulted MetLife for allegedly failing to provide an adequate justification for its termination of respondent's benefits—an inquiry that is more consistent with other circuits' burden-shifting approach than with deferential abuse-of-discretion review. *See id.* at 22a ("the plan administrator's rejection of Dr.

Patel's assessment, under the standard set out in the plan, was, in fact, arbitrary").[1]

Under a proper application of the standard of review proposed by the United States and compelled by *Firestone*, MetLife's decision to terminate respondent's benefits should be upheld even if MetLife operated under a conflict of interest. That decision was reasonable when the totality of the factual circumstances is taken into account—including the fact that respondent's treating physician had found her "able to work in a sedentary physical exertion level occupation" at the time that MetLife terminated her benefits, but thereafter changed his conclusion although nothing changed in the underlying medical records. Pet. App. 5a.[2]

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[1] Indeed, the United States itself has recognized that claim administrators have wide discretion to decide between conflicting medical evidence when evaluating a benefits claim and that those factual determinations should not be second-guessed by a court. *See* Br. for the United States as *Amicus Curiae* at 13, *Nord* (No. 02-469) ("A plan that confers discretion on the administrator to determine whether a claimant is disabled necessarily leaves to the administrator the discretion to resolve factual disputes, such as the nature and extent of the claimant's medical condition and physical limitations.").

[2] Respondent's treating physician had determined, in an evaluation that took place in March 2002, that she was able to return to work in a sedentary position. C.A. App. 238. The United States does not mention this fact in its brief, and instead obscures the factual history by stating that the physician "*ultimately* concluded that respondent's heart condition made her unable to 'return to any kind of even sedentary work.'" U.S. Br. 3 (emphasis added). The physician, however, did not reach his "ultimate[ ] conclu[sion]"—which flatly contradicted his earlier evaluation of the same medical evidence—until July 22, 2002, seven days *after* MetLife terminated respondent's benefits. C.A. App. 172, 204, 224.

The second question presented—whether MetLife's failure to provide a written refutation of the SSA determination undercuts its termination of respondent's benefits—is inextricably intertwined with the fact-intensive, totality-of-the-circumstances reasonableness inquiry that the United States proposes as the appropriate standard of review in this case. The United States acknowledges as much, conceding that "any application of the correct legal standard to this case[ ] may involve discussion of the treatment of the SSA award as part of the reasonableness analysis" (U.S. Br. 21) and that only when "taken together" by the Sixth Circuit did the purported conflict of interest and the outdated SSA disability determination culminate in the decision to reinstate respondent's benefits. *Id.* at 13 (alteration and emphasis omitted). The United States suggests that the issue therefore warrants briefing in connection with the standard-of-review question that it proposed. *Id.* at 21.

To ensure that all issues necessary to a correct resolution of this case are adequately briefed, however, the soundest course is for this Court to grant the petition in its entirety. If this Court concludes that the administrative claim file shows that MetLife was operating under a conflict of interest so that its determination should be reviewed under the standard proposed by the United States, full briefing of the SSA issue will materially assist the Court in applying the appropriate standard of review—which encompasses *all* of the circumstances surrounding a benefits determination—to the facts of this case.

B. The United States also fundamentally mischaracterizes the second question presented, which asks this Court to resolve whether a claim administrator must refute an outdated SSA disability deter-

mination *in writing* when terminating benefits after the treating physician states the disability has been resolved. The United States recommends that this Court deny review on this question because, according to the United States, the Sixth Circuit properly decided that "MetLife should have considered the award." U.S. Br. 20. But the Sixth Circuit did not consider that the evidence supporting the SSA decision dated from the time that MetLife initially approved respondent's claim, and that the treating physician had more recently opined (in March 2002) that his patient could return to work, only to change his conclusion after MetLife acted on it to terminate further benefits in July 2002. C.A. App. 172, 204, 224, 238. It instead faulted MetLife for failing to refute the outdated SSA award as part of its written benefits determination. *See* Pet. App. 25a ("MetLife acted . . . in unacknowledged conflict with the determination of disability by the Social Security Administration.").[3]

Even if it were not inextricably intertwined with the question posed by the government, that issue would warrant review because the Sixth Circuit's conclusion that MetLife should have provided a written explanation for reaching a decision different than that of the SSA is fundamentally at odds with this Court's holding in *Nord* that claim administrators need not give special weight to—or refute in writing—a treating physician's report presented by a claimant. 538 U.S. at 834. The Sixth Circuit's re-

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[3] Indeed, it is undisputed that, before its final benefits determination, MetLife received a copy of the SSA award from respondent's attorneys (C.A. App. 167-69, 327), and discussed the award with respondent on the telephone, explaining that the denial of her continued benefits was based on all of the information available to MetLife. *Id.* at 172.

quirement that a claim administrator provide a written refutation of an SSA disability determination is flatly inconsistent with *Nord*'s conclusion that courts may not impose "a discrete burden of explanation" in writing when administrators "credit reliable evidence"—here, the treating physician's March 2002 opinion—"that conflicts" with evidence presented at the behest of the claimant. *Id.* Moreover, because the SSA—unlike a claim administrator—is required to give special weight to a treating physician's opinion (20 C.F.R. § 404.1527(d)(2)), the Sixth Circuit's written refutation requirement gives a treating physician's opinion, even if it is credible, a degree of weight that this Court explicitly rejected in *Nord*.

Notwithstanding *Nord*'s clear holding, the lower courts are divided on the frequently recurring question whether a claim administrator must refute an SSA disability determination in writing. *See* Pet. for Writ of Cert. 17-19. The conflict with *Nord* and the division among the lower courts—together with the inextricable link with the question proposed by the government—provide a compelling basis for this Court to grant review of this question.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted.

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